DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 7 — 1 5

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 5, 1997

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 98 $ 0
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A
Pages 1-23

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A
Pages 1-23

10. SUBJECT OF AMENDMENT:
Hospital State Plan Amendment

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director, Dept. of Social Services

15. DATE SUBMITTED:
9-29-97

16. RETURN TO:
Division of Medical Services
615 Howerton Court
Jefferson City, MO 65109

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/30/97

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
08/05/97

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting
ARA for Medicaid and State Operations

23. REMARKS:
cc:
Martin
Yadner
Waite
ADRM/CO

SPA CONTROL
Date Submitted 09/29/97
Date Received 09/30/97

FORM HCFA-179 (07-92)

Instructions on Back

bstitute per letter dated 6/11/01"

INPATIENT HOSPITAL SERVICES (4.19a)
STATE PLAN SECTION 4.19A

Inpatient Hospital Services Reimbursement
Missouri-State Plan Section 4.19A

STATE PLAN SECTION 4.19B

*DMS Policy Unit has general responsibility for State Plan Section 4.19B. Institutional Reimbursement assists with the Outpatient Reimbursement Section.

AUG 28 2001

STATE: Missouri

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Inpatient Hospital Services Reimbursement Plan

I. GENERAL REIMBURSEMENT PRINCIPLES

A. For inpatient hospital services provided for an individual entitled to Medicare Part A inpatient hospital benefits and eligible for Medicaid, reimbursement from the Missouri Medicaid program will be available only when Medicaid's applicable payment schedule amount exceeds the amount paid by Medicare. Medicaid's payment will be limited to the lower of the deductible and coinsurance amounts or the amount the Medicaid applicable payment schedule amount exceeds the Medicare payments. For all other Medicaid recipients, unless otherwise limited by rule, reimbursement will be based solely on the individual recipient's days of care (within benefit limitations) multiplied by the individual hospital's Title XIX per-diem rate. As described in paragraph V.D.2. of this rule, as part of each hospital's fiscal year-end cost settlement determination, a comparison of total Medicaid-covered aggregate charges and total Medicaid payments will be made and any hospital whose aggregate Medicaid per-diem payments exceed aggregate Medicaid charges will be subject to a retroactive adjustment.

B. The Title XIX reimbursement for hospitals located outside Missouri and for federally-operated hospitals in Missouri will be determined as stated in section (XIII) of this plan.

C. The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per-diem, outpatient, and disproportionate share payments. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per-diem reimbursement - The per diem rate is established in accordance with section III. Hospitals and their per diem rates are described as either a general plan (GP) or disproportionate share (DS or DSH). The DS hospitals are described in section VI. and generally meet the mandated federal qualification and reimbursement criteria. Special state defined DS hospitals are also described.

2. Outpatient reimbursement is described in Attachment 4.19B.

3. Disproportionate share reimbursement - The discretionary disproportionate share payments which are allowable but not mandated under federal regulation are described in sections XV, XVI, and XVII. These Safety Net and Medicaid Add-Ons are subject to federal limitation described in OBRA 93 and section VI.D.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures buts limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report--Desk-reviewed Medicare/Medicaid cost report for the latest hospital fiscal year ending during the calendar year. (For example, a provider has a cost report for the nine (9) months ending 9/30/94 and a cost report for the three (3) months ending 12/31/94.) If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.

D. Charity Care - results from a providers policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances--Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Disproportionate Share Reimbursement. The discretionary disproportionate share payments which are allowed but not mandated under federal regulation are described in sections XV, and XVI, and XVII of this regulation. These Safety Net Medicaid Add-Ons are subject to federal limitation as described in the Omnibus Reconciliation Act of 1993 (OBRA 93) and subsection VI.D., of this regulation.

H. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

I. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost - Reports.

J. Nonreimbursable items. For purposes of reimbursement of reasonable cost, the following are not subject to reimbursement:

1. Allowances for return on equity capital;

2. Amounts representing growth allowances in excess of the intensity allowance, profits, efficiency bonuses, or a combination of these;

3. Cost in excess of the principal of reimbursement specified in 42 CFR chapter IV, part 413; and

4. Costs or services or costs and services specifically excluded or restricted in this plan or the Medicaid hospital provider manual.

K. Per Diem rates. The per diem rates shall be determined from the individual hospital cost report:

1. General Plan Per diem rate is calculated in accordance with section III. of the regulation. This rate is paid to hospitals not meeting the disproportionate criteria in section 6 of this regulation;

2. Disproportionate share per diem rate is calculated in accordance with section VI. Of this regulation for hospitals that met the Federally mandated disproportionate share criteria or the state specific criteria established in section VI. of this regulation.

L. Reasonable cost. The reasonable cost of inpatient hospital services is an individual hospital's Medicaid per-diem cost per day as determined in accordance with the general plan rate calculation using the base year cost report (by dividing allowable Medicaid inpatient costs by total Medicaid inpatient days, including nursery days).

M. Trend factor. The trend factor is a measure of the change in costs of goods and services purchased by a hospital during the course of one (1) year.

N. Children's hospital. An acute care hospital operated primarily for the care and treatment of children under the age of eighteen (18) and which has designed in its licensure application at least sixty-five percent (65%) of its total licensed beds as a pediatric unit as defined in 19 CSR 30-20.021(4)(F).

O. Hospital-sponsored primary care clinic–A clinic location which has met all of the following criteria:

1. The clinic shall not be physically located within a licensed hospital;

2. The clinic must be enrolled as a Medicaid provider;

3. The clinic is not certified by the Division of Health Standards and Quality, Health Care Financing Administration (HSQ/HCFA) as being part of any hospital; and

4. The sponsoring hospital has completed and returned the Hospital-Sponsored Primary Care Clinic Application to the Missouri Division of Medical Services by May 1, 1994, providing verification of the following:

   A. The sponsoring hospital and the clinic are subject to the bylaws and operating decisions of the same governing body; or

   B. The sponsoring hospital contributes at least five hundred thousand dollars ($500,000) annually towards the operation of the clinic.

III. Per-Diem Reimbursement Rate Computation.

Each general plan(GP) hospital shall receive a Medicaid per-diem rate based on its GP rate compiled in accordance with subsection III.A. Each disproportionate share hospital shall receive a rate compiled in accordance with subsection III.B.

A. The GP rate shall be lower of the most current Title XVIII Medicare rate of the GP per diem determined from the 1990 base year cost report in accordance with the following formula:

$$\text{PER DIEM} = \frac{(OC * TI)}{MPD} + \frac{CMC}{MPDC}$$

1. OC-The operating component is the hospital's TAC less CMC;

2. CMC The capital and medical education component of the hospital's TAC;

3. MPD-Medicaid inpatient days;

4. MPDC-MPD as defined in III.A.3. with a minimum utilization of sixty percent (60%) as described in paragraph V.C.4.;

5. TI-Trend Indices. The trend indices are applied to the OC of the per-diem rate. The trend indices for SFY 95 is used to adjust the OC to a common fiscal year end of June 30;

6. TAC-Allowable inpatient routine and special care unit expenses, ancillary expenses and graduate medical education costs will be added to determine the hospital's total allowable cost (TAC);

7. The GP per diem shall not exceed the average Medicaid inpatient charge per diem as determined from the base year cost report and adjusted by the TI;

8. The general plan per diem shall be adjusted for rate increases granted in accordance with subsection V.F., for allowable costs not included in the base year cost report.

B. Disproportionate Share (DS) Rate. The DS rate determined in accordance with section VI using the 1993 base year cost report shall be adjusted by the trend indices (TI) for subsequent state fiscal years.

C. Trend Indices (TI). Trend indices are determined based on the four (4) quarter average DRI Index for PPS-Type Hospital Market Basket as published in Health Care Costs by DRI/McGraw-Hill.

1. The TI are-

A. State Fiscal Year 1990-5.30%,
B. State Fiscal Year 1991-5.825%,
C. State Fiscal Year 1992-5.33%,
D. State Fiscal Year 1993-4.68%,
E. State Fiscal Year 1994-4.6%,
F. State Fiscal Year 1995-4.45%,
G. State Fiscal Year 1996-4.575%,
H. State Fiscal Year 1997-4.05%.

2. The TI for SFY 90 through SFY 92 are applied as a full percentage to the OC of the per-diem rate. The TI for SFY 93 through SFY 94 are applied one-half (½) to the individual hospital OC and one-half (½) times the statewide average weighted per-diem rate as of June 30. Only one-half (½) of the TI for SFY 95 through SFY 97 are applied to the individual hospital per diem rate. The remaining TI is considered in the Medicaid Add-On payment.

IV. Per-diem Rate New Hospitals.

A. Facilities Reimbursed by Medicare on a Per-Diem basis. In the absence of adequate cost data, a new facility's Medicaid rate may be its most current Medicare rate on file for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for this third fiscal year will be the lower of the most current Medicare rate on file by review date or the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

B. Facilities Reimbursed by Medicare on a DRG Basis. In the absence of adequate cost data, a new facility's Medicaid rate may be one hundred twenty percent (120%) of the average-weighted, statewide per-diem rate for two (2) fiscal years following the facility's initial fiscal year as a new facility. The Medicaid rate for the third fiscal year will be the facility's Medicaid rate for its second fiscal year indexed forward by the inflation index for the current fiscal year. The Medicaid rate for the facility's fourth fiscal year will be determined in accordance with sections of this plan.

V. Administrative Actions

A. Cost Reports

1. Each hospital participating in the Missouri Medical Assistance Program shall submit a cost report in the manner prescribed by the state Medicaid agency. The cost report shall be submitted within five (5) calendar months after the close of the reporting period. The period of a cost report is defined in 42 CFR 413.24(f). A single extension, not to exceed thirty (30) days, may be granted upon request of the hospital and the approval of the Missouri Division of Medical Services when the provider's operation is significantly affected due to extraordinary circumstances over which the provider had no control such as fire or flood. The request must be in writing and post marked prior to the first day of the sixth (6th) month following the hospital's fiscal year end.

2. The termination of or by a hospital of participation in the program requires that the hospital submit a cost report for the period ending with the date of termination within five (5) calendar months after the close of the reporting period. No extension in the submitting of cost reports shall be allowed when a termination of participation has occurred. The payments due the hospital shall be withheld until the final cost report is filed with the Division of Medical Services.

3. All cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the period prescribed in this subsection may result in the imposition of sanctions as described in 13 CSR 40-3.030.

B. Records

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR 413.20. For purposes of this plan statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims), respectively. All records must be available upon request to representatives, employees, or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO), or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

   (a) A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission;

   (b) Data required to be recorded in logs for each claim includes:

      (1) Recipient name and Medicaid number;

      (2) Dates of service;

      (3) If inpatient claim, number of days paid for by Medicaid, classified by general, newborn or specific type of intensive care;

(4) Charges for paid inpatient days or allowed outpatient services, classified by cost center as reported on cost report, except that allowed outpatient services may be recorded in the aggregate;

(5) Non-covered charges combined under a separate heading;

(6) Total charges;

(7) Any partial payment made by third party payors (claims paid equal to or in excess of Medicaid payment rates by third party payors shall not be included in the log);

(8) Medicaid payment received or adjustment taken; and

(9) Date of remittance advice upon which paid claim or adjustment appeared.

(c) A year-to-date total must appear at the bottom of each log page or after each applicable group total or a summation page of all subtotals for the fiscal year activity must be included with the log; and

(d) Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid fee schedule. This would include payments for General Relief recipients, payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a Medicaid provider type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR 413.17, must be available upon demand to those individuals or organizations as listed in Section V B.1. of this plan.

3. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of such reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by or on behalf of the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

4. The Missouri Division of Medical Services shall maintain any responses received on this plan, subsequent changes to this plan, and rates for a period of three (3) years from the date of receipt.

C. New, Expanded, or Terminated Services

1. A hospital, at times, may offer to the public new or expanded services for the provision of allowable inpatient or outpatient services which require Certificate of Need approval; or permanently terminate a service. Within six (6) months after such an event, the hospital must submit a budget which shall take into consideration new, expanded, or terminated services. Such budgets will be subject to desk review and audit. Upon completion of the desk review, reimbursement rates may be adjusted, if indicated. Failure to submit a request for rate reconsideration and budget shall disqualify the hospital from receiving a rate increase. Failure to submit a request shall not prohibit the division from reducing the rate in the case of a terminated service.

2. Failure to submit a budget concerning permanently terminated services may result in the imposition of sanctions.

3. Rate adjustments due to new or expanded services will be determined as total allowable project cost multiplied by the ratio of total inpatient costs (less swing bed cost) to total hospital cost as submitted on most recent cost report filed with the agency as of review date divided by total acute care patient days including all special care units and nursery, but excluding swing bed days.

4. Total acute care patient days (excluding nursery and swing bed days) must be at least sixty percent (60%) of total possible bed days. Total possible bed days will be determined using the number of licensed beds times three hundred sixty-five (365) days. If the days, including neonatal units, are less than sixty percent (60%), the sixty percent (60%) number plus newborn days will be used to determine the rate increase. This computation will apply to capital costs only.

D. Audits

1. A comprehensive hospital audit program shall be established in cooperation with the Missouri Medicare fiscal intermediary. Under the terms of the Common Audit Agreement, the Medicare intermediary shall perform the following:

   (a) Desk review all hospital cost reports;

   (b) Determine the scope and format for on-site audits;

   (c) Perform field audits when indicated in accordance with Title XIX principles; and

   (d) Submit to the state agency the final Title XVIII cost report with respect to each such provider.

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospital's fiscal year and shall make any recoupments necessary to ensure Title XIX payments for inpatient services do not exceed Title XIX reasonable costs. With the exception of those hospitals identified by the Medicare intermediary as nominal charge providers, the lower of aggregate per-diem cost or charge requirement will be applied. The state agency review shall not result in additional payments to the hospital.

3. Inpatient cost settlements determined in accordance with paragraph V.D.2. and initially determined on or after January 1, 1990 shall be waived proportionately, based on Medicaid inpatient days, for the time period the facility qualified for increased payments in accordance with subparagraph VI.A.4.

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.;

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services; and

4. A sole community provider reopening or adding certified acute care beds after October 1, 1992, who incurs additional costs for the purpose of providing inpatient acute care services in a community where inpatient acute care services were provided in state operated facilities, which are discontinued after October 1, 1992, will receive a rate increase for the additional cost incurred, not to exceed twenty three and four tenths percent (23.4%) of the inpatient acute care rate in effect on October 1,

*Substitute per letter dated 08/09/01 *

1992. This increase will be effective when the additional beds and services are made available, as documented by the Department of Mental Health, and will remain in effect as long as services satisfactory to the Department of Mental Health are made available to eligible persons who would have otherwise been served by the discontinued state-operated services. A sole community provider is a participating provider located in a community where there is no other participating hospital provider within a radius of twenty-five (25) miles and which is located within five (5) miles of a state-operated facility which discontinued inpatient acute care services after October 1, 1992. Adjustments provided under this part shall be considered reasonable costs for purposes of the determination described in paragraph V.D.2.

F. Rate Reconsideration

1. Rate reconsideration may be requested under this subsection for charges in allowable cost which occur subsequent to the base period described in section III on page 5. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid Agency:

   (a) Substantial changes in or costs due to case mix; or

   (b) New, expanded or terminated services as detailed in subsection V.C.

(c) When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

(a) The use of Medicare standards and reimbursement principles;

(b) The method for determining the trend factor;

(c) The use of all-inclusive prospective reimbursement rates; and

(d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program.

4. As a condition of review the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the State Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Agency's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty the sixty (60)-day period, the request shall be deemed denied.

G. Sanctions

Sanctions may be imposed against a provider in accordance with applicable state and federal regulations.

VI. Disproportionate Share

A. Impatient hospital providers may qualify as either a first tier or second tier disproportionate share hospital based on the following criteria. Hospitals shall qualify as disproportionate share hospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification.

1. If the facility offered non-emergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to those services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a Metropolitan Statistical Area, as defined by the federal executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer non-emergency obstetric services as of December 21, 1987;

2. As determined from the third prior year desk reviewed cost report, the facility must have either--

(a) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean Medicaid inpatient utilization rate for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded.

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

or;

(b) A low income utilization rate in excess of twenty-five percent (25%).

(1) The low-income utilization rate (LIUR) shall be the sum (expressed as a percentage) of the fractions, calculated as follows: